Information Summary and Recommendations

Chemical Dependency Counselors Sunrise Review

December 1995

Health Systems Quality Assurance

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Washington State Department of Health

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The Sunrise Review Process

Legislative Intent

It is the Legislature's intent to permit all qualified individuals to enter a health care profession. If there is an overwhelming need for the state to protect the public, then entry may be restricted. Where such a need to restrict entry and protect the public is identified, the regulation adopted should be set at the least restrictive level.

The Sunrise Act, RCW 18.120.010, states that a health care profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public and the potential for harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public can reasonably benefit from an assurance of initial and continuing professional ability; and
- The public cannot be protected by other more cost effective means.

After evaluating the criteria, if the legislature finds that it is necessary to regulate a health profession not previously regulated by law, the regulation should be consistent with the public interest and the least restrictive method. There are five types of regulation to be considered:

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.

2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business when a service is being performed for individuals involving a hazard to the public health, safety, or welfare.

3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practiced and, if required, a description of the service provided. A registrant could be subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

4. *Certification.* A voluntary process by which the state grants recognition to an individual who has met certain qualifications. Non-certified persons may perform the same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to persons who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensee is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

Overview of Proceedings

The Department of Health notified the applicant group, all professional associations, board and committee chairs, and staff of the Sunrise Review. Meetings and discussions were held and documents circulated to all interested parties.

Regulatory agencies in all other states were requested to provide sunrise reviews, regulatory standards, or other information which would be useful in evaluating the proposal. A literature review was conducted. Staff have reviewed all submitted information and asked for feedback from interested parties.

A public hearing was conducted in Tumwater on November 6, 1995. The hearing panel included staff from the Department of Health and the State Board of Health. Interested persons were allowed to give time limited presentations. There was an additional ten-day written comment period.

Following the public hearing and additional written comments, a recommendation was made based on all information received and in consultation with the public hearing panel. The applicant group and other interested parties were briefed on the draft recommendations. The proposed final draft will be reviewed and approved by the Health Systems Quality Assurance Assistant Secretary and the Department Secretary. The final report is transmitted to the Legislature via the Office of Financial Management.

Executive Summary

In February 1995, the Senate Health and Long-Term Committee chair Kevin Quigley forwarded SB5656 to the department for sunrise review. RCW 18.19 enacted in 1987 established certification of social workers, mental health counselors, and marriage and family therapists and registration for the remainder of counselors, with no specific reference to chemical dependency counselors. (Currently, state employees are exempt from the registration requirement.) The proposal calls for a voluntary certification program, one level higher than the current registration, for chemical dependency counselors.

The "applicant" consists of: The Chemical Dependency Professionals of Washington State, the Association of Alcoholism and Addictions Programs in Washington State, the Northwest Indian Council and Northwest Indiana Alcohol/Drug Specialist Certification board, the Washington Association of Independent Outpatient Providers, and Sundown M Ranch (a provider).

Findings

1. **The applicant is to be commended for agreeing to consider a wide range of options for the assurance of continuing competency.**

2. **Chemical dependency counseling is successful because of its grassroots, non-academic discoveries regarding how best to treat addiction.** There is no evidence that a Master's Degree is necessary to provide chemical dependency assessment and treatment.

3. **The applicant did not show current harm to the public from chemical dependency counselors.** The argument that professional recognition would lead to more and better treatment, and therefore is a benefit to the public, appears tenuous.

4. **There is a link between chemical dependency (both abuse and addiction) and a variety of social ills, but the link between a voluntary, professional, state certification program and a real affect on alleviating these problems is weak at best.**

5. **The applicants provided evidence from harm that occurs when another type of health care provider, who is not trained in recognizing chemical dependency, misdiagnoses and provides inappropriate treatment.**

6. **The Department of Health, Division of Alcohol & Substance Abuse (DSHS/DASA) states that their approved training programs appear to work well, and coordination with the two private certification boards is good.**

7. **There seems to be a general problem caused by third party payers refusing to recognize a profession that is not licensed or certified, despite the fact that**

credentialing level is determined on potential safety concerns, not cost-effectiveness of care or other reimbursement issues.

8. **The "public" would not benefit from yet another certification label being offered by chemical dependency counselors.**

Recommendations

1. **The proposal to increase the level of regulation of chemical dependency counselors from registration to certification should not be enacted.**

However, if there is legislation enacted on this issue, the department recommends the following:

- While not justified by the facts presented, if a master's degree is to be used as a benchmark, consider allowing the secretary to set appropriate "buy downs" of this education level through specialized training and experience.
- There should be a continuing competency requirement added, perhaps beginning with employer verification. The department could be authorized to work with the Advisory Council to establish other mechanisms.
- Consideration should be given to removing the grandfathering provision; if there is a legitimate case that unqualified providers are posing a danger, exempting them from these requirements is contradictory. A suitable period of time can be allowed for current providers to obtain their new credential. There also appear to be enough higher education slots to accommodate the additional persons (about 40%) who do not have at least a BA degree.

2. **Registered counselors who provide chemical dependency counseling should add elements to their disclosure statement (currently provided in statute).**

3. **DSHS should work with non-program, non-approved providers to encourage private certification or obtaining DSHS approval.**

4. **Add one chemical dependency counselor (using DASA or private certification as a determinant), one Advanced Practice Psychiatric Nurse, one psychologist, and one psychiatrist to the Secretary's Mental Health Advisory Council.**

5. **The Mental Health Advisory Council should be charged with reviewing current requirements and developing a suggested "core chemical dependency**

competency" for all appropriate health care providers (including physicians, social workers and psychologists, at a minimum).

6. **The Mental Health Advisory Council and the Office of the Insurance Commissioner should cooperate to educate health plans about the meaning of each level of regulation, and to encourage them to use chemical dependency counselors, when appropriate.**

Current Regulation

[For more detailed description, See Appendix A]

RCW 18.19 enacted in 1987 established certification of social workers, mental health counselors, and marriage and family therapists and registration for the remainder of counselors, with no specific reference to chemical dependency counselors. (Currently, state employees are exempt from the registration requirement.) RCW. 18.19.010 states:

> "The qualifications and practices of counselors in this state are virtually unknown to potential clients. Beyond the regulated practices of psychiatry and psychology, there are a considerable variety of disciplines, theories, and techniques employed by other counselors under a number of differing titles. The legislature recognizes the right of all counselors to practice their skills freely, consistent with the requirements of the public health and safety as well as the right of individuals to choose which counselors best suit their needs and purposes..."

There are currently 2,215 certified social workers, 2,532 certified mental health counselors, and 769 certified marriage and family therapists. There are 14,426 registered counselors. The Department of Health (DOH) reports few counselors have dual certification due to the different education and training requirements.

> There is a Department of Social and Health Services (DSHS), Division of Alcohol and Substance Abuse (DASA) program that certifies treatment service providers. WAC 440-22 defines chemical dependency counseling as "face to face individual or group contact using techniques and (a) led by a chemical dependency counselor (CDC) or CDC intern under direct CDC supervision, (b) directed toward patients and others who are harmfully affected by the use of mood altering chemicals or are chemically dependent; and (c) directed toward a goal of abstinence for chemical dependent persons." Treatment services are specified and defined. It is required that counseling programs be led "by a chemical dependency counselor (CDC) or CDC intern under direct CDC supervision".

A chemical dependency counselor is defined as a person registered, certified, or exempted by DOH, or qualified as a CDC under WAC-440-22-240. DASA reports as of April 1994, that 1,289 CDC's were employed and 397 CDC interns utilized in a counseling role at 432 DASA-approved sites. In addition, 648 CDC's were employed but not working as counselors at these sites. Applicants state there are as many as 1,000 counselors working *primarily* on chemical dependency issues outside of DASA-approved settings. The applicants state practitioners with certification in other counseling professions, psychiatrists, psychologists, and nurses may also be providing chemical dependency assessment and counseling as part of their work.

The Department of Licensing, the Department of Corrections, and The Office of the Superintendent of Public Instruction all have programs that require the use of providers meeting the DASA standards. (See Appendix 1 for additional details.)

Currently, chemical dependency certification in Washington is conducted by two private associations: Northwest Indian Alcohol/Drug Specialist Certification Board, based in Tacoma, and Chemical Dependency Counselor Certification Board, based in Spokane. The applicants state approximately 1,200 chemical dependency counselors pursue certified chemical dependency counselor (CCDC) status through either of these two bodies. Two national bodies also certify chemical dependency counselors.

Proposal for Sunrise Review

In February 1995, the Senate Health and Long-Term Committee chair Kevin Quigley forwarded SB5656 to the department for sunrise review. The proposal calls for a voluntary certification program, one level higher than the current registration.

> SB5656 states, "The legislature recognizes that chemical dependency affects a significant portion of the adults and youth of Washington state and each year tens of thousands of these individuals seek treatment from health care professionals. The legislature further recognizes that chemical dependency counseling has developed as a unique, interdisciplinary profession based on specific competencies, knowledge, and skills acquired through education, work experience, and life experience. Chemical dependency counselors possess a common foundation of skills and know-ledge unique to assessing and treating alcoholism and other drug addiction. The purpose of this act is to protect the public by identifying those individuals who have demonstrated a particular level of competency in the core functions of chemical dependency counseling and have met other standards of qualification, education, training, and experience in chemical dependency counseling."
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> "Twelve core functions of chemical dependency counseling" are defined in SB5656 as "assisting or attempting to assist a person to arrest chemical dependency and maintain abstinence, including, but not limited to, the application of the following strategies and skills, all specific to chemical dependency: screening; intake; orientation; diagnosis and assessment; treatment planning; counseling; case management; crisis intervention; client education; referral; reports and recordkeeping; and consultation with other professionals regarding client treatment and services.

Summary of Information Collected/Submitted

Department staff reviewed information received during the review process. Additional information was solicited from interested parties and further information was provided to the department voluntarily. In this "Summary of Information" section, the text is paraphrased by the department from all documentation received. It does not reflect the department's findings, which are found in a later section of this report.

The summary is divided, as best as it could be, into three parts which correspond to the three main criteria given by the legislature to determine if a profession should be regulated by the state and, if so, to what extent. The three criteria are (a) harm to the public, (b) benefit to the public, and (c) other means of regulation.

The "applicant" consists of: The Chemical Dependency Professionals of Washington State, the Association of Alcoholism and Addictions Programs in Washington State, the Northwest Indian Council and Northwest Indiana Alcohol/Drug Specialist Certification board, the Washington Association of Independent Outpatient Providers, and Sundown M Ranch (a provider).

A. Harm to the Public (of adopting or not adopting the proposal)

Applicant

The absence of minimum standards for practitioners in this profession exposes the public to considerable harm, and endangers the health, safety and welfare of over 500,000 alcoholic and drug addicted individuals in this state. Applicants will demonstrate that certification is necessary to identify persons comprehensively trained and experienced to assess and treat persons with this disease. The current regulatory system (registration and voluntary participation in a regulated DSHS program) is inadequate to prevent harm to the public. Certification is necessary to protect the public from unsupervised practice by untrained or incompetent individuals.

There is a strong connection between chemical dependency and wide range of social problems -- HIV/AIDS transmission, violence, child abuse, injury, etc. Between 10 and 15% of the adult population met criteria for alcohol abuse or dependence. Improper or inadequate treatment of persons with chemical dependency mean these problems will continue.

There are 500,000 chemically dependent people in Washington state and over 50,000 individuals seek treatment each year in state-approved chemical dependency treatment programs. Other individuals receive treatment from registered counselors and other credentialed health care providers.

Due to chemical dependency being a chronic, life-threatening disease that is related to dozens of medical conditions, potential for harm is not just emotional but also physical. There is also the potential for physical harm to an unborn child when ineffective or improper assessment or treatment is received.

Instances of inappropriate, ineffectual or harmful "counseling" occur daily beyond the purview of DSHS program licensure, DOH facility licensure, and DOH counselor registration authority. As the laws now stand, there is no mechanism to prevent incompetent persons from moving outside licensed programs to operate unlicensed private practices. When you consider that 10% of the adult population has a serious alcohol or other drug problem, the

need for consumer protection is critical. It becomes urgent when you consider that the Basic Health Plan and new enrollees in other plans will have no standard by which they can determine if they are seeking help from a health professional properly trained to treat this illness.

This problem is so pervasive, many untrained and unskilled persons see unlimited financial potential in offering services. Evidence of the perceived open market lies in the number of programs approved by DSHS has more than tripled in the last decade. Even more disconcerting is that the numbers of providers advertising chemical dependency or addiction counseling without state approval surpasses the number of approved programs in some communities.

The 100 or so chemical dependency counselors working in schools see thousands of young people across the state. The job descriptions require that they either meet the same requirements as the DSHS programs, or be a school nurse, school counselor, social worker, psychologist or children's mental health specialist. Therefore, many of the counselors in school have little or no preparation to do chemical dependency counseling.

Adult prisons are establishing in-house chemical dependency treatment services that are not regulated by DSHS or DOH. The counselors hired for juvenile detention centers operated by DSHS are not required to be registered. **[NOTE**: DSHS has corrected this information. All Department of Corrections sites operated using a program manual approved by DSHS and the goal is for full approval. In addition, all 9 FTE chemical dependency counselors work in a DSHS approved program under contract.**]**

There is a potential for harm through the loss of liberty. State laws provide for involuntary commitment based upon recommendations of a chemical dependency counselor; notable among these is the "Becca Bill." A credential for chemical dependency counselors will incorporate a level of protection against improper evaluations and unnecessary commitment.

Certification brings a professional recognition that will be an incentive for other providers to make the appropriate referrals to qualified CDC's, thereby alleviating some of these problems through proper treatment.

Problems also occur when there is improper assessment, failure to recognize chemical dependency as the primary problem, failure to use abstinence as the treatment goal, failure to differentiate chemical dependency, mental illness, and dual disordered persons. These are often problems with psychologists, psychiatrists, or other mental health and health care professionals, who do not have the training to properly diagnose chemical dependency. We need CDC's "everywhere" to get people into the right programs in time.

Also there is evidence of cases where a counselor could not get a private certification from one board, but was certified by another board, creating a situation of a "bad" practitioner who was certified. They could not get hired because of their bad reputation, so they became an independent practitioner.

Department of Licensing

Due to existing laws that require persons convicted of a DUI or placed on deferred prosecution to participate in education or treatment, it is essential that counselors are regulated to ensure that there are consistent competency requirements and disciplinary regulations. The lack of such oversight clearly represents possible harm to the public as potential safety threats to the community do not receive appropriate treatment.

Other counselor professions have preceded the certification of alcohol/drug counselors. It is overdue for this profession.

Department of Social and Health Services

The Division of Alcohol and Substance Abuse (DASA) supports certification by DOH. Currently, the oversight of chemical dependency counselors is a split responsibility between DASA and DOH. DASA sets the standards for counselors and monitors the verification of credentials by administrators who employ chemical dependency counselors in DASA certified treatment agencies. Disciplinary action is carried out by DOH.

All counselors working in DASA agencies must register with DOH, registration alone does not guarantee qualification standards or competence. DASA does recognize the private certifications, but this is voluntary. Because some practice outside of DASA certified agencies, there is a group of persons who may practice virtually unregulated.

Pierce County Social Services

Based on close observation of the chemical dependency treatment system, it is absolutely essential to impose certification requirement upon chemical dependency counselors. Failing to do so would be detrimental to the public interest and could potentially cause great harm.

Individuals struggling to overcome the disease of addiction are in a vulnerable state and could easily be victimized by unqualified or unscrupulous practitioners. A consistent method must be in place to require both qualification and accountability of any person who represents himself or herself as a counselor.

Washington Association of Sheriffs and Police Chiefs

It is well known the extensive costs to society in both human and financial terms. There is loss of life, a wide range of criminal activity, domestic problems and the enforcement costs associated to these situations. Highly trained personnel are a big factor in reducing the costs to the public in the area of drug and alcohol addiction.

Rev. James E. Royce, Seattle University

Our present regulation allows many unqualified persons to do addiction counseling. Some of these have their own recovery as their only qualification, but some are degree professionals who are otherwise competent but lack specialized knowledge and supervised experience. I do not speak out of any bias against psychologists, as I was three-time chair of our state psychology licensing board, but most psychologists just do not understand addiction. The same is true of physicians.

A question has been raised as to whether colleges and universities could handle the increase in applicants (under a certification program with additional education requirements). I assure you that Seattle University could.

This is a life-threatening and socially disruptive disease for which there is no place for amateurs doing treatment.

Diane Baily, ARNP

I am concerned that the proposal, and the related DSHS rule changes, provides barriers to individuals with advanced degrees in Addiction Medicine, Nursing, Social Work, and Psychology from obtaining employment and practicing in the chemical dependency treatment field.

Pacific Northwest Chapter, Employee Assistance Professionals Association

We may refer to private practitioners who are not approved by DSHS but do have training and experience with chemical dependencies. These therapists may be certified social workers, certified mental health counselors or psychologists. However, these credentials do not address training and knowledge in chemical dependency. A few individuals may have pursued private certification in chemical dependency but on the whole we must rely on the practitioner's word or reputation for their expertise.

State certification of chemical dependency counselors would meet an important need in the world of employee assistance programs. We would have a uniform standard we could rely upon in judging the skills of therapists for whom we have no other knowledge. We would know there is one source who would have information about those therapists who have practiced. We would have more confidence knowing there is a certifying and monitoring agency.

Washington State Psychological Association

We support certification with conditions:

(1) Education standards are inadequate. Must have Master's degree.
(2) Redefine supervision requirements -- too burdensome on other providers.
(3) Remove treatment goal (abstinence) from statute. Could be a goal but shouldn't be in statute.

The Washington State Psychological Association (WSPA) agrees it is a "bio-psycho-social problem" and therefore it needs more of a mental health base than is proposed. Between 20 and 50 percent of substance abusers have at least one co-existing psychological problem.

WSPA provides several case examples where current DSHS regulations regarding counselor training have proved insufficient to prevent harm to the public because training in the diagnosis and treatment of mental disorders is inadequate. WSPA has seen a consistent

under-referral of cases to them for treatment of mental disorders. Patients may even be actively discouraged from seeking such treatment.

The American Psychological Association is developing its own chemical dependency certification for psychologists.

Washington Mental Health Counselors Association

There is too little education required for the certification level. Suggestions:
(1) Mandate chemical dependency services by DASA programs only.
(2) All mental health professions have training in the recognition of chemical dependency.
(3) Establish separate chemical dependency registration program.

Washington Association of Marriage and Family Therapists

Washington Association of Marriage and Family Therapists (WAMFT) opposed the creation of a new certification category for chemical dependency counselors. The existing categories are sufficient to cover the skills that ought to be required for this type of counselor. To allow this certification to become law would seriously undermine the attempt the state has already made to set consistent standards that protect the public and inform them of the level of a counselor's education.

When the state decided to certify counselors, there were three categories created. Due to certification for the social worker and marriage and family categories requiring a master's degree, it was soon determined that the mental health counselor certified category should also require a master's degree. Already-certified counselors were given a prescribed time period to acquire a master's degree.
The application argues that mental health and chemical dependency counseling should remain separate. In the last 20 years, the field of mental health has made great strides in bringing chemical dependency to the awareness and into the training of its clinicians. On the other side, chemical dependency counselors have not enhanced their mental health training by seeking advanced degrees. The horror stories of mental health counselors not detecting chemical dependency issues to disastrous consequences can be matched with stories of chemical dependency counselors who didn't look for or weren't able to address significant mental health issues with their clients.

It is significant that the main studies cited in the application (Carkhuff and the Minnesota Model) are over 25 years old. One has to wonder why newer research is not cited. Much has been learned in 25 years. Many states now combine the training of both fields for certification or licensure.

WAMFT suggests either:
(1) There should be a special registered counselor category for chemical dependency.
(2) The education should level be increased to a master's degree to support certification.

Washington State Adolescent Chemical Dependency Treatment Providers

Treatment programs that collectively make up our organization employ staff that have completed or in the process of completing the rigorous academic and experiential requirements in DSHS/DASA rules. While this has served us reasonably well, no mechanism exists that will accurately and in a timely fashion, demonstrate the credentialing of a given staff. Staff are subsequently unable to produce quick and easy verification of their training and are open to mistrust by their clients and client families.

National Association of Social Workers
Washington State Society of Clinical Social Workers
Washington Association of Marriage and Family Therapists
Washington Mental Health Counselors Association

The application does not prove there is harm now being done by chemical dependency counselors so how will this application change the situation to protect the public?

It is not the process of certification that is in question, but specifically it is the certification of chemical dependency counselors which we believe is contrary to the spirit and intent of RCW 18.19. Under current law, all state-certified groups have the requirements of a masters degree or higher, supervised practicum, post-masters experience and supervision under a certified practitioner, and a standardized examination. The proposal does not meet this standard.
Chemical dependency counseling is not a degree but only a limited area of practice. The public is not protected by the proposal that 33 quarter hours in counseling, some form of supervision, and an exam that tests knowledge of chemical dependency is suitable for independent certification.

Under the proposal, a certified individual would be unable to correctly ascertain if there are co-existing mental disorders due to lack of appropriate training. This in itself fails to protect the public as there is a great room for error in focus and treatment if requisite ability to recognize co-existing disorders is inadequate.

Applicants have not demonstrated harm under the sunrise criteria.

Lakeside Milam Care Unit

The client who is victimized by an incompetent counselor may not know for years that he has indeed been victimized. Clients who are addicted and allowed to practice controlled drinking, for instance, are more than happy with the service; they are generally elated to be able to continue drinking while "recovering." In this regard I know of only three known cases in which a client counseled by an incompetent practitioner drove while under the influence and

injured other people. The only reason that the incompetence came to light was the uncertified practitioner advertised a controlled drinking program.

It is however logical to assume that unchecked incompetence will damage clients and the question then is to what degree there are existing safeguards to ensure competency. My experience since 1979 reflects the following. First, during 10 years as chief of the office of alcoholism for DSHS roughly 90% of the client grievances found to have merit were rooted in the incompetence or inexperience of counselors working at small agencies. Second, DSHS conducts on-site reviews only once every three to five years. During that time a struggling agency may indeed employ unqualified, albeit enthusiastic, staff who work for little pay so that they may enter the field. Third, since DASA no longer checks individual counselor qualifications on request, it is left to the administrator, who may not understand the WAC requirements, to hire qualified personnel. Small agencies (70% of the total) are tempted even more today to hire less costly, unqualified staff in face of the constriction of chemical dependency services by managed care.

In addition, 24% of Lakeside-Milam Recovery Center clients in 1994 indicated they used the Yellow Pages as the primary referral source.

While Lakeside and other long time accepted service providers may retain the highest standards of employee and experience, newer, smaller agencies struggling to survive can and do settle for less. We owe it to the public to mandate state certification for chemical dependency counselors and ensure a minimum level of competency throughout the service system.

Advanced Practice Psychiatric Nurses

No method of regulation guarantees competency. However, the certification qualifications and standards set forth in Chapter 18.19 RCW provide to the public the assurance that a certain level of education and training has been achieved. The minimum qualification of a Master's degree gives the public a standard by which to judge a professional in the mental health field. The inclusion of Chemical Dependency Counselors in RCW 18.19, under this proposal, would violate the spirit of this law by reducing the qualifications standards significantly. We believe strongly that any certification under this statute should be at the Master's degree level.

The high rate of co-morbidity (38-50%) with other serious mental disorders necessitates that the primary treating counselor is competent in assessment and treatment of mental disorders, as well as skilled in the assessment of chemical dependency. The qualifications being proposed do not require a higher degree of academic or clinical training, nor adherence to nationally recognized standards ascribed by other professional groups.

We are concerned that the certification of chemical dependency counselors would create a misconception in the marketplace that such counselors are trained to provide a full range of counseling to those who suffer from chemical addiction. The implication being that certification translates into the same level of training as other certified professionals.

These counselors are a valuable part of an interdisciplinary team, but we have serious concerns with their request for certification.

B. Benefit to the Public (of adopting or not adopting the proposal)

Applicants

With a certification program, consumers would have a single agency to which complaints and requests for information can be directed. Without a single state credential, applicants may greatly exaggerate their qualifications in the area of chemical dependency or otherwise misrepresent themselves. State certification will upgrade the quality of care and better weed out counselors with deficient skills and provide a more complete employment history.

Courts are employing services through probation departments. While expected to, not all are referring offenders to DSHS approved programs. Probation officers who make independent recommendations would be well served by a state certification program. Many other agencies, such as nursing homes and employer workplace programs, are incorporating chemical dependency counselors into their staffs, but no standard exists by which the public can ascertain whether a counselor is actually trained or effective.

Certification provides a credential that employers in non-approved programs can require prior to employment working with dependent people, thus screening out individuals without adequate training and education. The certification process being proposed calls for a renewal every two years that incorporates employer performance reviews, providing a continuity of information about performance not available under a registration program. The applicant remains open to other suggestions for "continuing competency" processes.

Another benefit to the public would be a decrease in the physical harm associated with chemical dependency. The well-publicized Lauria Grace death would have been avoided if a qualified chemical dependency counselor had been involved earlier in the case.

By establishing qualifications for chemical dependency assessment and treatment, the primary health care system and the public in general will be better able to identify and employ professionals who are qualified. Quality assurance programs and payers look at programs based on credentials. Certification will provide these outside agencies with a credential to incorporate into their standards of practice and provider requirements.

DSHS has recommended dual qualification for counselors so they can treat addicts with concurrent mental health disorders. This certification can be easily attained by persons already certified in mental health and working with the dual disordered patient population.

Certification is not just a matter of protecting the public. It is essential to the infrastructure of health care and health reform. The National Commission for Quality Assurance is now requiring health maintenance organizations and managed care companies to assure state-

credentialed professionals deliver services. Since we have always used program certification, rather than individual certification, it is essential that we step up to this demand.

Department of Social and Health Services

We believe it would be a positive service to the public to have some form of state-sanctioned credential which would apply to all practitioners of chemical dependency counselors, clearly indicating those that have met a minimum standard. Not only would the public be more able to identify a qualified practitioner when seeking services, but schools, courts, and social service agencies would be better able to quickly verify qualified practitioners when hiring staff.

DSHS would change its DASA certification process to require counselors in their programs to obtain DOH certification.

Pierce County Social Services

Certification serves a variety of beneficial purposes. First, requiring state-approved credentials will benefit and protect the public by ensuring that chemical dependency counselors possess the minimum standards necessary to perform effectively and that they are accountable. Further, state participation will ensure that established counselors continue their training to keep pace with accelerating growth in the field of chemical dependency counseling. It will also provide an avenue of recourse through a governmental agency to individuals who feel they have suffered some wrong at the hands of a counselor. Lastly, certification registries will afford schools, courts, and other entities a reliable means for identifying qualified counselors to perform a variety of specialized services, and individuals in need of treatment can be assured of the integrity of their counselor before committing to a treatment program.

Superintendent of Public Instruction

Office of Superintendent of Public Instruction (OSPI) manages two programs impacted by the qualifications of personnel employed to intervene with students who are using or may be at risk of using tobacco, alcohol, and other drugs. These are the federal Safe and Drug-Free Schools and Communities program (SDFSCA), and the Washington State Omnibus Alcohol and Controlled Substances Act. SDFSCA funds can be used to employ intervention specialists in schools. State statute (RCW 28A.070.100) lists the required qualifications. These specialists may have training in a variety of categories, most specifically listed as professions certified by DASA. School districts are often concerned about credentials and welcome this assurance of competency of the professionals they hire.

Spectrum Health, Inc.

We are a healthcare management services company that manages provider panels for insurance and managed care companies. We see problems created by addictions care not being well integrated into traditional healthcare delivery.

Due to addiction, we pay higher taxes by not recognizing the proper pathways to care, and society ends up footing the bill for solutions that involve civil actions and pile legal costs on top of treatment costs. We pay higher insurance premiums because we have not come to grips with treating the issues consistently or aggressively. We are treating the physical symptomology of the disease by primary care providers, rather than the early stages by addictions specialists.

Potential consumers should not be left at the mercy of anyone who chooses to call themselves a provider. We need to know that individuals purporting to have the knowledge and skills to offer treatment really do. We need to know that providers who abuse or treat incompetently can be sanctioned or eliminated from delivering care. We need to know that providers can assess appropriately and have a predictable process for connecting individuals to other health care professionals. Certification can be a giant step in the direction of improving the care to which our citizens are exposed.

The state benefits from formalizing a process of identifying minimum competencies of individuals providing addictive care.

Managed Care Washington
(consortium of 28 community mental health centers)

It is time for the state to take the necessary steps to insure that the 3,800+ chemical dependency counselors operating in the state are practicing in a manner that promotes the health and well-being of clients.

This is a group of treatment providers that have historically evaluated themselves based upon results, a worthwhile approach. However having minimum standards for training, work experience and examination will only serve to legitimize the results of their work. Further, the public needs to feel confident that the person engaging them in treatment has met the baseline standards to call themselves a Certified Chemical Dependency Counselor. To this date, that title's meaning is broad and defined by the holder of the title.

Ethix Northwest

We are repeatedly asked to make referrals to counselors qualified in chemical dependency and recovery treatment. Additionally, there are instances where alcoholics and other drug addicts are being provided mental health services, sometimes including addictive medications, without the recognition of their chemical dependent condition.

Existing certification standards for mental health, social work or marriage and family therapists are not sufficient to assure that the provider is qualified to identify a chemically dependent person, let alone treat one properly.

Currently, as part of our credentialing process, we are attempting to identify mental health practitioners who are qualified to work with chemically dependent patients. The existence of a credible Department of Health certification program in this regard would be a great help to us and would contribute substantially to the improvement of health treatment for the people of Washington.

Washington State Adolescent Chemical Dependency Treatment Providers

As relates to chemical dependency treatment, the consuming public is insurance companies, schools an courts, companies, and patients. All have an expectation that State Certification is their best assurance that their counselor is capable, competent and professional. Certification also represents the best protection for the public from unqualified practitioners, and that the state will guarantee due process and advocacy if a complaint becomes necessary.

Counselor certification is a logical extension of the state's need to set standards that create safeguards for its citizens. There are currently programs and practitioners that treat chemical dependent clients, yet have no specific chemical dependent training. Certification will prevent misrepresentation by these entities and require compliance to uniform standards of preparation, qualification, and treatment.

Washington Association of Sheriffs and Police Chiefs

We see the value of drug and alcohol treatment as part of the solution in reducing the drug and alcohol use. These people can help reduce the carnage occurring on our highways from drunk drivers. Certified counselors will help to assure us that the person in need of treatment is getting a counselor with the expertise and skills necessary.

Frederick A. Montgomery, M.D.

I believe that certification is necessary as it assures me that the person to whom I am referring will have a measured degree of competence as determined by the requirements of their certification. Existing counselor certifications for mental health, social work, or marriage and family therapy are not sufficient and many of the patients on whom I wish an assessment completed, are already seeing those professionals without adequate attention to their alcohol and drug problems By the same token, I am hesitant to refer a patient to a person without credentials, no matter how good they may be. In addition, my confidence in referring would be enhanced if I knew that the individual had met standards of education and experience. Personally, I would recommend periodic examinations as we do with many of the board certified physicians.

Chelan-Douglas Health District

The demand for an educated, skilled counselor with a professional approach to working with the many persons whose lives are affected by alcohol and substance abuse has been substantiated in terms of outcomes. An educated, qualified counselors should be certified in the fields to maintain standards and help to affect positive outcomes in the direction of their clients' lives.

C. Other Means of Regulation (other than those in the proposal)

Applicants

Regulation of the program or service, rather than the individual counselor, is inappropriate. Limitations include: (1) program approval is voluntary; (2) standards cannot incorporate key elements of counselor standards, tests of competency, etc.; (3) disciplinary action is limited to the program, not the individual; (4) counselor standards placed within program rules create confusion; and (5) program approval does not apply to many settings where chemical dependency counseling takes place.

A registration program as is now in place does not allow qualifications to be enumerated or tested for. It is easier to prevent unethical conduct through training and certification. In addition, state employees are exempt from the registration program, as are counselors who volunteer (i.e., do not charge a fee for their services). The environment in which counselors work is substantially different from the one that existed when the registration act was passed. A higher level of regulation is now justified.

Private certification has covered only about 30% of counselors, so that mechanism is not effective enough to be relied upon. Inability to screen out from one board a person who fails one private board's certification adds to the problem.

This proposal is for voluntary certification. However, the applicant recognizes that licensure affords a stronger consumer protection vehicle.

Department of Health Literature Review

The state of Colorado has four "psychotherapy" categories of providers who are either licensed without an exclusive scope of practice or non-licensed. The categories are counselor, marriage and family therapist, psychologist, and social worker. This allows a person to demonstrate competency and obtain a state credential with all the inherent benefits. Only those persons licensed can say they are and those who choose not to, do not have to become licensed. All discipline for the four professions is handled by a multi-disciplinary board.

National Association of Social Workers
Washington State Society of Clinical Social Workers
Washington Association of Marriage and Family Therapists
Washington Mental Health Counselors Association

Chemical Dependency Counselors may want to pursue creation of a separate registered counselor category as a means to better identify their associates. This is similar to the category of registered hypnotherapists.

The more appropriate solutions are to regulate business employers, practitioners of the program or service, rather than the chemical dependency employee practitioners. This allows the practitioner to practice their skills freely, consistent with the requirements of public health and safety. It also protects the public by ensuring that adequate supervision is provided to these counselors commensurating with their proven abilities. It is also more cost effective in time, staff, and funding for the government.

Public Hearing

A public hearing was held at the Labor and Industries Building on November 6, 1995. Twenty-one people testified. Several written comments augmenting presentations at the hearing were supplied during the written comment period.

Findings

1. **The applicant is to be commended for agreeing to consider a wide range of options for the assurance of continuing competency.** They have gone beyond endorsing the concept and making substantive suggestions for carrying it out.

2. **Chemical dependency counseling is successful because of its grassroots, non-academic discoveries regarding how best to treat addiction. There is no evidence that a Master's Degree is necessary to provide chemical dependency assessment and treatment.** However, both mental health and chemical dependency counselors are not able to diagnose every illness their patients have. They treat many of the same patients because these patients have a higher-propensity for dual illnesses than a patient with a physical injury or illness.

3. **Applicant did not show current harm to the public from chemical dependency counselors. The argument that professional recognition would lead to more and better treatment, and therefore is a benefit to the public, appears tenuous.** Case examples provided by the psychologists as supporting documentation were compelling, but it was hard to see whether these were legitimate professional disagreements or substandard care. In either case, another voluntary certification program would seem to have little impact.

4. **There is a link between chemical dependency (both abuse and addiction) and a variety of social ills, but the link between a voluntary, professional certification program and a real affect on alleviating these problems is weak at best.** Many other factors go into the problems, as well as the fact that participants in chemical dependency programs do so through a variety of motivations, methods of referrals, and results. Should there be a link shown between a voluntary certification program and the number of certified people providing services increasing, then a different finding could be made. To do this, it would have to be shown that third party payers and other users and providers of these services would recognize the certification and maximize the use of certified persons.

5. **Applicants provided evidence from harm that occurs when another type of health care provider, who is not trained in recognizing chemical dependency, misdiagnoses and provides inappropriate treatment.** These are most often: social workers, psychologists, and psychiatrists. Clearly there is a linkage between mental health and chemical dependency in many patients, and there should be even greater coordination and cross referral among the various treatment providers. If there is a problem of integrating addiction treatment into primary care, a voluntary certification program will not help to solve it.

6. **DSHS/DASA states that their approved training programs appear to work well, and coordination with the two private certification boards is good.** DASA provides on-site inspections about once every three years. DSHS believes they cannot require participants in their approved programs to have private certification,

but that they could require state certification. OSPI programs require that someone diagnosing and treating dependency meet the DASA standards.

7. **There seems to be a general problem caused by third party payers refusing to recognize a profession that is not licensed or certified, despite the fact that credentialing level is determined on potential safety concerns, not cost-effectiveness of care or other reimbursement issues.**

8. **The "public" would not benefit from yet another certification label being offered by chemical dependency counselors.** There are already numerous, well-used labels that counselors use. An additional one, albeit a state-sanctioned one, will not help to clarify the situation for the public. As only about 10% of clients are self-referred (i.e., pick from the yellow pages), the importance of labels to the "public" is reduced further.

Recommendations

1. **The proposal to increase the level of regulation of chemical dependency counselors from registration to certification should not be enacted.**

However, if there is legislation enacted on this issue, the department recommends the following:

- While not justified by the facts presented, if a master's degree is to be used as a benchmark, consider allowing the secretary to set appropriate "buy downs" of this education level through specialized training and experience.

- There should be a continuing competency requirement added, perhaps beginning with employer verification. The Department could be authorized to work with the Advisory Council to establish other mechanisms.

- Consideration should be given to removing the grandfathering provision; if there is a legitimate case that unqualified providers are posing a danger, exempting them from these requirements is contradictory. A suitable period of time can be allowed for current providers to obtain their new credential. There also appear to be enough higher education slots to accommodate the additional persons (about 40%) who do not have at least a BA degree.

Rationale: This issue has many complexities that are initially hard to sort out. On the one hand, assertions that "lower paid" staff are routinely "unqualified" are based on tenuous argument. On the other, competent, timely counseling (and proper referral to additional types of providers as needed) could help alleviate many problems caused by widespread substance abuse. The questions that emerged: would a state program that assesses only initial competency, and perhaps has some check on on-going competency, actually reduce death and injury? Does a chemical dependency counselor need to be competent in both

assessment and treatment of mental disorders, or just assessment? Does a voluntary certification program, by itself, create enough market demand to result in the overwhelming majority of providers obtaining certification? If not, then what good does it serve? Should the department ascertain a prospective employee's qualifications, rather than the employer? Do the arguments about putting all the professional regulation under one roof (the Department of Health) and the regulation of programs under another (DSHS) make for more or less effective government?

The "bottom line" is that a voluntary certification program, that is redundant to current DSHS and private certification, only shifts workload to DOH without raising the level of protection of the public. The legislature stated in establishing Chapter 18.19 that there are many types of counseling and the public should be able to pick the one that works best for them. Further categorizing "specialty" counselors and trying to funnel more people toward one type of provider is seemingly inconsistent with that approach.

However, should evidence appear that certification, along the lines of the proposal, would actually generate demand for and use of more qualified providers, without unfairly restricting the practice of other types of providers who are competent to provide that service, then the legislature might want to reconsider this recommendation in light of those new facts. Presently, the department was not provided with any firm indication that this would, indeed, happen with the predicted results.

Additional recommendations

2. **Registered counselors who provide chemical dependency counseling should add elements to their disclosure statement (currently provided in statute).** These elements would include the type of chemical dependency training they have, and what the treatment goal is.

Rationale: The disclosure statement is an effective way to provide patient education. Adding a few specific, chemical dependency related provisions would help patients make appropriate choices. There would also be an incentive for obtaining an adequate level of training and education so they can more effectively market their services to clients.

3. **DSHS should work with non-program, non-approved providers to encourage private certification or obtaining DSHS approval.** This includes informing officials in involuntary commitment and other state programs about the availability of approved or certified chemical dependency programs and counselors.

Rationale: Some of the identified problems are with state-run or state-supported programs that make use of chemical dependency providers. As several mechanisms already exist for identifying quality providers (DASA and private certification), agencies using chemical dependency counselors should be made aware of them and encouraged to use them. This is how the probation officers use the system now. Even programs that do not accept DSHS

funds could benefit from voluntarily becoming DSHS certified, along with the benefits cited with the applicants' proposal.

4. **Add one chemical dependency counselor (using DASA or private certification as a determinant), one Advanced Practice Psychiatric Nurse, one psychologist, and one psychiatrist to the Secretary's Mental Health Advisory Council.** Due to the cross-professional issues involved, all related professions should be represented.

Rationale: Cross-fertilization of ideas among professions has been recognized for some time as a means to work out problems. In this case, a serious problem identified is the lack of inter-disciplinary training between chemical dependency and mental health. Bolstering professional representation on the Council will help the Secretary to address these concerns.

5. **The Mental Health Advisory Council should be charged with reviewing current requirements and developing a suggested "core chemical dependency competency" for all appropriate health care providers (including physicians, social workers and psychologists, at a minimum).** The Council should work with all other boards, commissions, and the Secretary to implement these standards.

Rationale: After adopting #4 above, this recommendation will address specific solutions to the problem.

6. **The Mental Health Advisory Council and the Office of the Insurance Commissioner should cooperate to educate health plans about the meaning of each level of regulation, and to encourage them to use chemical dependency counselors, when appropriate,** and that DASA approval or private certification are good standards to use.

Rationale: There seems to be a widespread misperception, among both providers and third party payers alike, that licensing or certification indicate some level of cost-savings or effectiveness worthy of third party payment. Sunrise criteria do not judge effectiveness; harm to the public is the key factor. The state needs to do a better job of letting the concerned parties know that level of credentialing should not be used as an indication of worthiness to be reimbursed.

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LITERATURE REVIEW

Brown, S. Alcoholics anonymous: an interpretation of its spiritual foundation--concepts that give AA its therapeutic value. Reprinted from Behavioral Health Management 1994 Jan-Feb: 25-7.

Chalmer, D. & Wallace, J. Evaluation of patient progress.

Curriculum Review Committee, Addiction Training Center Program, Center for Substance Abuse Treatment. Addiction counselor competencies. U.S. Department of Health and Human Services 1995. Feb: 10(2).

International Certification and Reciprocity Consortium. 12 core functions - definitions.

Montgomery, F.A. What psychiatrists don't know about alcoholism. Addiction Letter 1993

National Institute on Alcohol Abuse and Alcoholism. Alcoholism: an inherited disease. U.S. Department of Health and Human Services 1985.

Valle, S. Reprint of Chapter 2, Alcoholism Counseling: Issues an Emerging Profession 1994.

Wallace, J. Critical issues in alcoholism therapy.

Wallace, J. Reprint of Chapter 4, New Light on the Disease.

Wallace, J. Working with the preferred defense structure of the recovering alcoholic.

APPENDIX A

Detailed Description of Current Regulation

[Most of this section was prepared by State Board of Health Staff]

RCW 18.19 enacted in 1987 established certification of social workers, mental health counselors, and marriage and family therapists and registration for the remainder of counselors, with no specific reference to chemical dependency counselors. (Currently, state employees are exempt from the registration requirement.) RCW. 18.19.010 states:

> "The qualifications and practices of counselors in this state are virtually unknown to potential clients. Beyond the regulated practices of psychiatry and psychology, there are a considerable variety of disciplines, theories, and techniques employed by other counselors under a number of differing titles. The legislature recognizes the right of all counselors to practice their skills freely, consistent with the requirements of the public health and safety as well as the right of individuals to choose which counselors best suit their needs and purposes..."

There are currently 2,215 certified social workers, 2,532 certified mental health counselors, and 769 certified marriage and family therapists. There are 14,426 registered counselors. DOH reports few counselors have dual certification due to the different education and training requirements.

RCW 18.19.060 requires counselors, whether registered or certified, to provide an "information disclosure to clients." The disclosure is to contain information regarding: counselor practice, including any relevant education and training, therapeutic orientation of the practice, the proposed course of treatment where known, financial requirements, and any other information DOH requires by rule; right of clients to refuse treatment; and responsibility of clients for choosing the provider and treatment modality which best suit them. Counselors must also provide each client with a statement which reads, "Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment." Clients must also be provided a list of acts of professional misconduct specified under RCW 18.130.180 together with a contact name, address, and phone number within DOH. Both counselor and client must sign a statement noting disclosure information has been provided, read, and understood.

WAC 440-22, substantially revised in February 1994, sets forth requirements for Department of Social and Health Services (DSHS), Division of Alcohol and Substance Abuse (DASA)-certified treatment service providers. WAC 440-22-005 defines chemical dependency counseling as "face to face individual or group contact using techniques and (a) led by a chemical dependency counselor (CDC) or CDC intern under direct CDC supervision, (b) directed toward patients and others who are harmfully affected by the use of mood altering chemicals or are chemically dependent; and (c) directed toward a goal of abstinence for chemical dependent persons." Treatment services are specified and defined in WAC 440-22-010 and include: detox; residential treatment; outpatient treatment; assessment, including DUI (driving under the influence) assessments, and diagnosis requested by the courts to determine a client's involvement with alcohol and other drugs and to recommend a course of action; and information and assistance. It is required that counseling programs be led "by a chemical dependency counselor (CDC) or CDC intern under direct CDC supervision". Additional requirements which include use of CDCs exist for those providing:

- detoxification services (WAC 440-22-350)
- intensive inpatient, recovery, or long-term residential services (WAC 440-22-400)
- outpatient services (WAC 440-22-450)
- opiate dependency treatment (440-22-500)
- free-standing ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) services (WAC 440-22-550)
- DUI (driving under the influence) assessment services (WAC 440-22-560)
- information and crisis services (440-22-610)

A chemical dependency counselor is defined as a person registered, certified, or exempted by DOH, or qualified as a CDC under WAC-440-22-240.

To become a CDC, one must first serve as a CDC intern. WAC 440-22-200 requires a CDC intern: not have a history of alcohol or drug misuse for two years prior to becoming an intern; have obtained nine quarter or six semester college or university credits, with three quarter or two semester credits in each of three topic areas -- survey of chemical dependency; physiological actions of alcohol and other drugs; and chemical dependency counseling techniques; and be registered or certified as a counselor, or have a written exemption from DOH.

WAC 440-22-220 sets forth requirements for completing the internship. These include: an additional 24 quarter or 16 semester credits in various specified subjects; an additional 180 hours of state-approved training in relapse prevention, youth chemical dependency assessment and counseling, cultural awareness, HIV/AIDS brief risk interventions, and other skills; and 2,000 hours of supervised experience as a CDC intern, with minimum requirements in several specified clinical areas. Effective February 1, 1997, a two-year college degree or equivalent, with CDC-intern course requirements, is mandated. Additional requirements exist for probation assessment officers (WAC 440-22-225) and youth CDCs (WAC 440-22-230). There are WAC requirements for 60 hours of continuing education every two years.

DASA reports as of April 1994, that 1,289 CDCs were employed and 397 CDC interns utilized in a counseling role at 432 DASA-approved sites. In addition, 648 CDCs were employed but not working as counselors at these sites. Applicants state there are as many as 1,000 counselors working *primarily* on chemical dependency issues outside of DASA-approved settings. The applicants state practitioners with certification in other counseling professions, psychiatrists, psychologists, and nurses may also be providing chemical dependency assessment and counseling as part of their work.

Requirements exist for county-designated chemical dependency specialists under WAC 440-25-040. They include two years of full-time paid experience as a CDC and demonstrated knowledge in a number of areas.

State DUI statutes (RCW 46.61 and 10.05) reference use of DASA-approved programs. The Department of Licensing requires assessments and treatment be provided by DASA-approved providers as a condition of license reinstatement.

The Department of Corrections (DOC) provides chemical dependency treatment in correctional institutions. DOC is in the process of becoming a DASA-certified provider and will subcontract with other agencies to provide CDCs.

The Office of the Superintendent of Public Instruction (OSPI) provides grants to school districts for substance abuse intervention under RCW 28A.170.080. These services are provided by a "substance abuse intervention specialist" who may be one of the following:

- An educational staff associate certified as a school counselor, school psychologist, school nurse, or school social worker under State Board of Education rules;
- An individual meeting CDC qualifications under DASA rules;
- A DSHS-employed counselor, social worker, or other qualified professional;
- A licensed psychologist;
- A children's mental health specialist.

Diagnosis and assessment, counseling and aftercare specifically identified with treatment of chemical dependency is to be performed only by personnel who meet the same qualifications as are required of a DASA-qualified CDC. [RCW 28A.170.080(2)]. OSPI reports about 300 individuals are employed through the grants. Only about 15 are employed primarily to provide diagnostic, treatment, counseling, and aftercare services as specified in RCW 28A.170.080(2). An unknown number of chemical dependency counselors are employed by school districts independent of the Substance Abuse Awareness Program.

Currently, chemical dependency certification in Washington is conducted by two private associations: Northwest Indian Alcohol/Drug Specialist Certification Board, based in Tacoma, and Chemical Dependency Counselor Certification Board, based in Spokane. The applicants state approximately 1,200 chemical dependency counselors pursue certified chemical dependency counselor (CCDC) status through either of these two bodies. The applicants note that until recently, counselors certified by the Northwest Indian Board were called chemical dependency specialists (CDS). Both boards use the title CCDC I for persons who meet standards similar to those required by DASA for CDCs except there are additional requirements for written examinations, oral case presentations or interviews, and a minimum of three peer evaluations, one of which must be provided by an employer. CCDC I's meet greater experience and training re-requirements. The Chemical Dependency Counselor Certification Board also offers the title CCDC III for those persons who meet CCDC II requirements and possess a master's or higher degree. The applicants state all CDCs within DASA-approved programs, as well as some chemical dependency counselors working outside these programs, would be qualified to take the written examinations to become CCDCs.

Two national bodies also certify chemical dependency counselors. The International Certification and Reciprocity Consortium for Alcohol/Drug Counselors (ICRC) and National Association of Alcoholism and Drug Addiction Counselors Certification Commission (NAADAC) set requirements for experience and training substantially different and in some areas higher than DASA standards. Washington has an exemption from the higher ICRC requirements, thus enabling counselors certified by the Northwest Indian Alcohol/Drug Specialist Certification Board to receive ICRC certification. Individuals with ICRC certification also use the initials CCDC. NAADAC has two designations -- National Certified Addiction Counselor (NCAC) Level I which requires 6,000 hours of experience, and NCAC Level II which requires 10,000 hours of experience. Counselors conducting alcohol/drug assessments on interstate transportation workers must be certified by NAADAC under federal law, and federal correctional programs require this certification for their contracts. There are 194 NAADAC-certified counselors in Washington.

Several other titles are used by Washington chemical dependency counselors. Prior to DSHS' 1994 revision of WAC 440-22, CDCs were called "qualified chemical dependency counselors" (QCDCs). Several statutes and administrative rules have not been amended since then and still refer to "qualified chemical dependency

counselors". It is reported that a small number of practitioners still use QCDC in their titles. CAS ("certified addiction specialist) is a nationally-conferred title usually held by medical doctors or others with a doctorate and is obtained by writing to the American Academy of Health Providers in the Addictive Disorders and attesting to one's expertise in the field. CAC (Certified Alcoholism/Addiction Counselor) is a title which used to be conferred by the Chemical Dependency Counselor Certification Board but has been replaced by CCDC. There are still practitioners who continue to use the old title.

National accreditation bodies -- including COA (Council on Accreditation of Services for Families and Children); CARF (Commission on Accreditation of Rehabilitation Facilities); and JCAHO (Joint Commission on Accreditation of Healthcare Organizations) -- reference the use of personnel meeting applicable state regulatory requirements. WAC 440-22-105 allows DASA to "deem accreditation by a national chemical dependency accreditation body" if the treatment provider is DASA-certified and national accreditation time intervals meet or exceed state expectations.

APPENDIX B

Chemical Dependency Counselor Certification in Other States

Listed below are states known to have state-recognized credentialing. Most of these have adopted certification or licensure through statute; a few have adopted certification through authority to the state alcohol and drug agency. The terms "licensure" and "certification" as used below are consistent with Washington State use of that terminology, as can best be translated from that state's law. The list includes the year of first enactment of credentialing (and year of increased regulation where applicable), whether mandatory or voluntary (with statutory authority when known), and whether the state is associated with the 39-state International Certification and Reciprocity Consortium (ICRC) or has independent standards and exams.

State-Operated Credentialing of Chemical Dependency Counselors[1]**:**

1. **Nevada** -- 1984 mandatory certification (Ch. 458.025) -- scope of practice and title protected; voluntary certification 1977-84 - independent
2. **Virginia** -- 1977; voluntary certification (Ch. 54.1-2400.6) - independent
3. **Nebraska** -- 1978; voluntary certification/mandatory for chemical dependency program counselors (Ch. 83-164) - ICRC
4. **Montana** -- 1978; voluntary certification/mandatory for chemical dependency program counselors - independent
5. **Michigan** -- 1982; voluntary certification/1995 mandatory - ICRC
6. **Hawaii** -- 1985; voluntary certification (HRS 321-196) - ICRC
7. **Vermont** -- 1986; voluntary certification (8VSA Ch. 107) - ICRC
8. **Connecticut** -- 1987; voluntary certification (PA 83-557 and 87-136) - ICRC
9. **Louisiana** -- 1987; voluntary certification (Ch. 51- R.S. 37.3371) - ICRC.
10. **North Dakota** -- 1987; mandatory licensure (Ch. 43-45) - independent
11. **Tennessee** -- 1989; voluntary certification (33-2-801) - independent
12. **Maine** -- 1990; mandatory licensure (Title 32, Ch. 81-1-6200) - ICRC
13. **Texas** -- 1991; mandatory licensure (Vernon's Article 4512o) - ICRC
14. **Minnesota** -- 1992 - voluntary certification/1994 mandatory (148C.01) - ICRC
15. **Kansas** -- 1993; voluntary registration/mandatory for chemical dependency program counselors (SB 458, 1993) - independent
16. **North Carolina** -- 1993; voluntary certification (Ch. 90-113.30) - ICRC
17. **Rhode Island** -- 1994; voluntary certification (Ch. 5-69) - ICRC
18. **New Hampshire** -- 1980's; voluntary certification /required for counselors in public programs (RCV 172) - ICRC

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[1] In this list **"licensure"** reflects the scope of practice is defined and restricted to only licensed counselors, **"certification"** protects the title only, and **"registration"** implies signing up, with no qualifications needed. With regard to certification, **"voluntary"** reflects that the counselor can practice without this credential; **"mandatory"** means that chemical dependency counselors in that state *must* be certified.

States Where Statute Delegates Chemical Dependency Counselor Credentialing to Private Bodies:

19. **Missouri**: Substance abuse counselors are exempt from state licensure requirement if certified by the Missouri Substance Abuse Counselors' Certification Board, a private non-profit ICRC group.
20. **Iowa**: Under administrative rule, "persons providing treatment [in substance abuse programs] shall be certified by the Iowa Board of Substance Abuse Certification (a private nonprofit, ICRC Board) or be eligible for certification." (Rule 643 of the Substance Abuse Commission).
21. **Ohio**: All counselors and social workers are required to be licensed by the state or certified by the Ohio Credentialing Board for Chemical Dependency Professionals (a private on-profit ICRC body) as a certified chemical dependency counselor (Ch. 4757.16).
22. **South Carolina**: Credentials chemical dependency counselors at five levels through the Department of Alcohol and Other Drug Abuse Services. This voluntary certification is being moved from the state to the private chemical dependency counselor association.
23. **Pennsylvania**: Insurance laws in Pennsylvania recognize for third-party payment chemical dependency counselors who are state-certified addictions counselors (by the Pennsylvania Chemical Abuse Certification Board, a member of the national ICRC) or certified by a national chemical dependency counselor certification body.

States Where Chemical Dependency Counselor Credentialing is in Sunrise:

24. **Georgia** is now undergoing Sunrise Review on proposed alcohol and drug counselor licensure law; bill is pending in the legislature.

Pending State Chemical Dependency Counselor Certification/Licensure Legislation:

25. **New Jersey** -- Mandatory licensure legislation introduced 1994 and pending final action.
26. **Massachusetts** -- Licensure legislation introduced 1994; now in Senate Ways and Means Committee.
27. **Utah** -- Voluntary certification legislation introduced 1995

States Where Chemical Dependency Counselor Certification is Expected in Next Session:

28. **Arizona** State Board of Behavioral Health has created a committee to craft a state licensure law for chemical dependency counselors.
29. **West Virginia** -- State chemical dependency counselor association has hired a lobbyist and is preparing legislation for licensure.
30. **Kentucky** -- State chemical dependency counselor association is preparing legislation to introduce in 1996 to license chemical dependency counselors.
31. **Connecticut** -- Introduced legislation in 1995 for mandatory licensure; died in Joint Committee on Public Health. Resubmission expected.

S-0807.2

SENATE BILL 5656

State of Washington **54th Legislature** **1995 Regular Session**

By Senators Kohl, Palmer, Moyer, C. Anderson, Deccio and Quigley

Read first time . Referred to Committee on .

AN ACT Relating to chemical dependency counselors; amending RCW 18.19.020, 18.19.030, and 18.19.070; adding a new section to chapter 18.19 RCW; and creating new sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature recognizes that chemical dependency affects a significant portion of the adults and youth of Washington state and each year tens of thousands of these individuals seek treatment from health care professionals. The legislature further recognizes that chemical dependency counseling has developed as a unique, interdisciplinary profession based on specific competencies, knowledge, and skills acquired through education, work experience, and life experience. Chemical dependency counselors possess a common foundation of skills and knowledge unique to assessing and treating alcoholism and other drug addiction. The purpose of this act is to protect the public by identifying those individuals who have demonstrated a particular level of competency in the core functions of chemical dependency counseling and have met other standards of qualification, education, training, and experience in chemical dependency counseling.

Sec. 2. RCW 18.19.020 and 1991 c 3 s 19 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Certified chemical dependency counselor" means a person certified to practice chemical dependency counseling pursuant to section 6 of this act.

(2) "Certified marriage and family therapist" means a person certified to practice marriage and family therapy pursuant to RCW 18.19.130.

((~~(2)~~)) (3) "Certified mental health counselor" means a person certified to practice mental health counseling pursuant to RCW 18.19.120.

((~~(3)~~)) (4) "Certified social worker" means a person certified to practice social work pursuant to RCW 18.19.110.

((~~(4)~~)) (5) "Client" means an individual who receives or participates in counseling or group counseling.

((~~(5)~~)) (6) "Counseling" means employing any therapeutic techniques, including but not limited to social work, mental health counseling, marriage and family therapy, chemical dependency counseling, and hypnotherapy, for a fee that offer, assist or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, ((~~or~~)) behavioral, or chemical dependency problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential. For the purposes of this chapter, nothing may be construed to imply that the practice of hypnotherapy is necessarily limited to counseling.

((~~(6)~~)) (7) "Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee, including for the purposes of this chapter, hypnotherapists.

((~~(7)~~)) (8) "Department" means the department of health.

((~~(8)~~)) (9) "Secretary" means the secretary of the department or the secretary's designee.

(10) "Twelve core functions of chemical dependency counseling" means assisting or attempting to assist a person to arrest chemical dependency and maintain abstinence, including, but not limited to, the

application of the following strategies and skills, all specific to chemical dependency:

(a) Screening;

(b) Intake;

(c) Orientation;

(d) Diagnosis and assessment;

(e) Treatment planning;

(f) Counseling;

(g) Case management;

(h) Crisis intervention;

(i) Client education;

(j) Referral;

(k) Reports and recordkeeping; and

(l) Consultation with other professionals regarding client treatment and services.

Sec. 3. RCW 18.19.030 and 1991 c 3 s 20 are each amended to read as follows:

No person may, for a fee or as a part of his or her position as an employee of a state agency, practice counseling without being registered to practice by the department under this chapter unless exempt under RCW 18.19.040. No person may represent himself or herself as a certified social worker, certified mental health counselor, ((~~or~~)) certified marriage and family therapist, or certified chemical dependency counselor without being so certified by the department under this chapter.

Sec. 4. RCW 18.19.070 and 1994 sp.s. c 9 s 501 are each amended to read as follows:

(1) The Washington state mental health and chemical dependency quality assurance council is created, consisting of nine members appointed by the secretary. All appointments shall be for a term of four years. No person may serve as a member of the council for more than two consecutive full terms.

Voting members of the council must include one social worker certified under RCW 18.19.110, one mental health counselor certified under RCW 18.19.120, one marriage and family therapist certified under RCW 18.19.130, one chemical dependency counselor certified under section 6 of this act, one counselor registered under RCW 18.19.090,

one hypnotherapist registered under RCW 18.19.090, and two public members. Each member of the council must be a citizen of the United States and a resident of this state. Public members of the council may not be a member of any other health care licensing board or commission, or have a fiduciary obligation to a facility rendering health services regulated by the council, or have a material or financial interest in the rendering of health services regulated by the council.

The secretary may appoint the initial members of the council to staggered terms of from one to four years. Thereafter, all members shall be appointed to full four-year terms. Members of the council hold office until their successors are appointed.

The secretary may remove any member of the council for cause as specified by rule. In the case of a vacancy, the secretary shall appoint a person to serve for the remainder of the unexpired term.

(2) The council shall meet at the times and places designated by the secretary and shall hold meetings during the year as necessary to provide advice to the secretary.

Each member of the council shall be reimbursed for travel expenses as authorized in RCW 43.03.050 and 43.03.060. In addition, members of the council shall be compensated in accordance with RCW 43.03.240 when engaged in the authorized business of the council. The members of the council are immune from suit in an action, civil or criminal, based on their official acts performed in good faith as members of the council.

NEW SECTION. **Sec. 5.** Within sixty days of the effective date of this section, the secretary shall appoint a five-person chemical dependency counselor certification advisory committee to propose to the secretary, for his or her consideration, rules, educational requirements, tests, and procedures to carry out chemical dependency counselor certification. The committee shall be composed of:

(1) One chemical dependency counselor nominated by the Northwest Indian chemical dependency certification board;

(2) One chemical dependency counselor nominated by the chemical dependency counselor certification board of Washington state;

(3) One chemical dependency counselor not certified by any private chemical dependency board but meeting standards of qualification under the department of social and health services;

(4) One administrator of a chemical dependency treatment program approved by the department of social and health services; and

(5) One past consumer of chemical dependency counseling.

This section shall expire October 1, 1999.

NEW SECTION. **Sec. 6.** A new section is added to chapter 18.19 RCW to read as follows:

(1) The department shall issue a certified chemical dependency counselor certificate to any applicant meeting the following requirements:

(a) Completion of a minimum of thirty-three quarter credits or twenty-two semester credits in course work pertaining to chemical dependency and skills development in the twelve core functions of chemical dependency counseling;

(b) Completion of an additional one hundred eighty clock hours of training, or equivalent course work from an accredited college or university, in topics relating to the twelve core functions of chemical dependency counseling, which must include relapse prevention counseling, youth chemical dependency assessment and counseling, and ethics;

(c) Documentation of a minimum of two thousand clock hours of directly supervised counseling experience as a chemical dependency counselor in a chemical dependency treatment program approved by the department of social and health services;

(d) Successful completion of a recognized chemical dependency counselor examination based on the twelve core functions of chemical dependency counseling recommended by the chemical dependency counselor certification advisory committee and approved by the department; and

(e) Submission to the department of a completed application and all necessary documentation and fees.

(2) An applicant certified by the national association of alcoholism and drug abuse counselors or the international alcohol and other drug abuse certification and reciprocity consortium may be certified in this state without examination. Other applicants certified as chemical dependency counselors in another state may be certified in this state after successful completion of the examination required by the department.

(3) Until July 1, 1998, the department shall issue a certified chemical dependency counselor certificate to a person who provides:

(a) Verification of current qualified status as a chemical dependency counselor recognized by the department of social and health

services or evidence of certification by a chemical dependency counselor certification board currently recognized by the department of social and health services; and

(b) Submission of a completed application and payment of necessary fees.

(4) Certified chemical dependency counseling is that aspect of counseling that involves the provision of individual and group therapeutic contact to patients and others who are harmfully affected by the use of mood-altering chemicals or are chemically dependent, with a goal of total abstinence for all chemically dependent persons. Chemical dependency counseling is based on recognition that chemical dependency is a chronic disease that is biophysical as well as psychological, and its treatment involves a complex, holistic approach.

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